

IN THE SUPREME COURT OF CALIFORNIA

In re)	
)	
ANDERSON HAWTHORNE,)	CAPITAL CASE
)	No. S116670
On Habeas Corpus.)	
)	

**BRIEF OF THE AMERICAN ASSOCIATION
ON MENTAL RETARDATION (AAMR) AND
THE ARC OF THE UNITED STATES,
AMICI CURIAE**

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INTEREST OF AMICI CURIAE

Amici curiae are national professional and voluntary organizations in the field of mental disability.

The American Association on Mental Retardation (AAMR), founded in 1876, is the nation's oldest and largest interdisciplinary organization in the field of mental retardation. Among its most important professional activities is the production and periodic updating of a manual of terminology and classification for use by professionals in the field. Currently in its tenth edition, this manual provides the primary definition of mental retardation. Its commentary is the most authoritative analysis of the application of that definition and source of professional guidance for the evaluation of individuals who may have mental retardation. (See AAMR, *Mental Retardation: Definition, Classification, and Systems of Supports* (10th ed. 2002).)

The Arc of the United States (formerly the Association for Retarded Citizens of the United States), through its approximately 900 state and local chapters, is the largest national voluntary organization in the United States devoted solely to the welfare of the more than seven million children and adults who have mental retardation and their families.

These organizations have long been involved in assisting legislators and judges in shaping public policy and legal protections for people with

mental retardation. Through their state and local chapters, they led the efforts in state legislatures to obtain the passage of statutes preventing the execution of defendants with mental retardation. (See Ellis, *Disability Advocacy and the Death Penalty: The Road from Penry to Atkins* (2003) 33 N.M. L.Rev. 173.) They have also participated as amici curiae before the Supreme Court of the United States concerning this issue. (See, e.g., Brief of Amici Curiae American Association on Mental Retardation, the Arc of the United States et al., in *Atkins v. Virginia* (2002) 536 U.S. 304 [122 S.Ct. 2242, 15 L.Ed.2d 335] (hereafter *Atkins*) [originally submitted in *McCarver v. North Carolina* (No. 00-8727)]).

Since the *Atkins* decision, amici have been actively involved in assisting state legislatures and courts in the implementation of the Supreme Court's decision.

INTRODUCTION

The purpose of the present Brief is to offer this Court the benefit of the clinical expertise and practical experience of amici and their members. Mental retardation professionals regularly employ the definition of mental retardation and perform clinical assessments of defendants who may have mental retardation. Amici do not address the particulars of the evidence concerning petitioner Hawthorne's mental disability. Rather, this Brief focuses on the general issues that arise from the clinical definition of

mental retardation. It is amici's hope that this will prove helpful to this Court in its task of providing guidance to the lower courts. Those courts will have the initial responsibility of fact-finding and assessing the merits of individual *Atkins* claims raised in postconviction challenges brought by California defendants who are under sentence of death.

This Brief will first discuss the accepted clinical definition under which an *Atkins* claim will be evaluated, and the particular elements of that definition. (See Part I, *infra*.) The Brief then discusses the kind of clinical assessments necessary for the resolution of an *Atkins* claim, assessments that can be provided by competent mental retardation professionals. (See Part II, *infra*.) The Brief concludes with an explanation of why death penalty eligibility under *Atkins* is a separate and distinct question from the issues of competence to stand trial and insanity. (See Part III, *infra*.)

I. THE ACCEPTED CLINICAL DEFINITION OF MENTAL RETARDATION CONSISTS OF THREE ELEMENTS

In *Atkins v. Virginia* (2002) 536 U.S. 304, the Supreme Court of the United States held that the Eighth Amendment prohibits the execution of any individual who has mental retardation. The Court left to the states, in the first instance, "the task of developing appropriate ways to enforce the constitutional restriction upon [their] execution of sentences." (*Atkins*, *supra*, 536 U.S. at p. 317.) In response to the *Atkins* decision, the

California Legislature enacted a definition of mental retardation and established procedures for adjudicating mental retardation claims in the context of new capital prosecutions. “[M]entally retarded’ means the condition of significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested before the age of 18.” (Pen. Code, § 1376, subd. (a).)¹

California’s statutory definition is fully consistent with professional practice in the field of mental retardation. Its language directly tracks the definition adopted in 1983 by the American Association on Mental Retardation (AAMR) (previously known as the American Association on Mental Deficiency). This formulation of the AAMR definition has been widely adopted by legislatures and courts. (See, e.g., *Atkins*, *supra*, 536 U.S. at p. 308, fn. 3; Ellis, *Mental Retardation and the Death Penalty: A Guide to State Legislative Issues* (2003) 27 Mental & Physical Disability L.Rptr. 11, 12-13 (hereafter *Legislative Guide*)). Equally important, it is the same definition that mental retardation professionals routinely use in assessing cognitive disability in a variety of non-legal settings, including

¹ The same definition has been used in California law in a variety of contexts. (See, e.g., Pen. Code, § 1001.20; *In re Krall* (1984) 151 Cal.App.3d 792, 795-796 [199 Cal.Rptr. 91, 93].) Although the procedures provided in section 1376 address only new prosecutions, there is no suggestion that the Legislature intended a different definition of mental retardation to be applied to postconviction cases.

special education, provision of habilitation services, and determination of eligibility for public benefits.² This definition has also been adopted by the American Psychiatric Association. (American Psychiatric Assn., Diagnostic and Statistical Manual of Mental Disorders (4th ed. Text Revision 2000) p. 41 (hereafter DSM-IV-TR).)

All commonly used versions of the definition of mental retardation, including that adopted by the California Legislature, have three basic components: (1) measurable cognitive impairment (described as “significantly subaverage general intellectual functioning”); (2) a real-world impact on the individual’s life (described as “deficits in adaptive behavior”); and (3) manifestation of the disability during the developmental period, generally meaning that the disability became apparent at birth or during childhood.

Amici will discuss the implications of these elements of the definition for the evaluation of *Atkins* claims. With the assistance of experienced clinicians, trial courts should have little difficulty applying these elements in individual cases.

² See, e.g., The State of the States in Developmental Disabilities (Braddock et al. edits., 5th ed. 1998) page 3; Luckasson et al., *The 1992 AAMR Definition and Preschool Children* (1996) 34 Mental Retardation 247; Lowitzer et al., *AAMD’s 1983 Classification in Mental Retardation as Utilized by State Mental Retardation/Developmental Disabilities Agencies* (1987) 25 Mental Retardation 287; National Research Council, *Mental Retardation: Determining Eligibility for Social Security Benefits* (Reschly et al. edits., 2002).

A. COGNITIVE IMPAIRMENT

Assessing whether an individual has mental retardation begins with measuring impairment in cognitive functioning. (It is the beginning, and not the end, because the intellectual impairment must be accompanied by deficits in adaptive behavior, which will be discussed below.) The degree of impairment necessary to satisfy this first prong of the definition is described as “significantly subaverage general intellectual functioning.” This term of art has a specific clinical meaning.

For decades, the term “significantly subaverage” has been used by mental retardation professionals to describe the level of impairment found in individuals whose performance on standardized intelligence tests places them two standard deviations below the mean; that is, in the lowest two and a half or three percent of the population.³ Every individual who scores in

³ AAMR, *Mental Retardation: Definition, Classification, and Systems of Support* (10th ed. 2002) page 58 (hereafter AAMR, *Mental Retardation*, 2002); AAMR, *Mental Retardation: Definition, Classification, and Systems of Supports* (9th ed. 1992) page 5; American Association on Mental Deficiency (later renamed AAMR), *Classification in Mental Retardation* (8th ed. 1983) page 11; American Association on Mental Deficiency, *Manual on Terminology and Classification in Mental Retardation* (7th ed. rev. 1973) page 11; DSM-IV-TR, *supra*, at pages 41-42.

Thus, contrary to the assertion by the Attorney General that “significantly subaverage general intellectual functioning” describes a *subset* of people with mental retardation (see, e.g., Return to Order to Show Cause at p. 2 (hereafter Return)), the phrase is the universally accepted clinical term that describes the intellectual impairment shared by *all* people with mental retardation.

this range has a substantial cognitive impairment. While the presence or absence of “significantly subaverage general intellectual functioning” is diagnosed, and thus defined, by intelligence tests, it is not possible to identify a single, arbitrary IQ score as the upper boundary.⁴

The Supreme Court recognized in *Atkins*, “Not all people who claim to be mentally retarded will be so impaired as to fall within the range of mentally retarded offenders about whom there is a national consensus.” (*Atkins, supra*, 536 U.S. at p. 317.) Some claims for Eighth Amendment protection will fail because the defendant’s intellectual functioning is not “significantly subaverage.” But the clinical literature makes clear that this determination requires careful assessment of individual factors, and cannot be reduced to a single inflexible rule about IQ scores.

Clinical standards offer guidance for establishing which defendants satisfy this prong of the definition. AAMR has identified the “criterion for diagnosis [as] approximately two standard deviations below the mean, considering the standardized error of measurement for the specific assessment instruments used and the instruments’ strengths and

⁴ The clinical literature offers no support for the Attorney General’s suggestion that the category of mental retardation, and thus the protection of *Atkins* and section 1376, applies only to individuals who score below 60 on IQ tests. (See Return, *supra*, at pp. 2-3; Memorandum of Points and Authorities in Support of Return, *supra*, at pp. 9-10.) It is clear from *Atkins* that the Eighth Amendment protection encompasses all individuals who have mental retardation. (*Atkins, supra*, 536 U.S. at pp. 320-321.)

limitations.” (AAMR, Mental Retardation, 2002, *supra*, at p. 14.) In terms of numerical measurements, this has been identified as “an IQ standard score of approximately 70 to 75 or below, based on assessment that includes one or more individually administered general intelligence tests developed for the purpose of assessing intellectual functioning. These data should be reviewed by a multidisciplinary team and validated with additional test scores or evaluative information.” (AAMR, Mental Retardation: Definition, Classification, and Systems of Supports (9th ed. 1992) p. 5.)

The American Psychiatric Association reaches a similar conclusion: “[I]t is possible to diagnose Mental Retardation in individuals with IQs between 70 and 75 who exhibit significant deficits in adaptive behavior. Conversely, Mental Retardation would not be diagnosed in an individual with an IQ lower than 70 if there are no significant deficits or impairments in adaptive functioning.” (DSM-IV-TR, *supra*, at pp. 41-42; see also *id.* at p. 48.) “It is clear that neither of these organizations intends for a fixed cutoff point for making the diagnosis of mental retardation. Both specify consideration of adaptive behavior skills and the use of clinical judgment.” (AAMR, Mental Retardation, 2002, *supra*, at p. 58.)⁵

⁵ Clinical experience over the last two decades has heightened professional awareness that this flexibility is crucial in making an accurate diagnosis. But even earlier formulations of the definition recognized the

The particular circumstances of an individual's testing and the differences among IQ instruments mean that the upper boundary of mental retardation can never be fixed at a precise IQ score. "The assessment of intellectual functioning through the primary reliance on intelligence tests is fraught with the potential for misuse if consideration is not given to possible errors in measurement. An obtained IQ standard score must always be considered in terms of the accuracy of its measurement." (AAMR, Mental Retardation, 2002, *supra*, at p. 57.) One reason for this is relatively minor differences among IQ instruments, including their scoring methodology. An "important source of possible variation lies in test content differences across different scales and between different age levels on the same scale. . . . Variations may also be attributed to differences in the standardization samples, to changes between different editions of the same scale, to shifts to an alternative scale as an individual's chronological

danger of focusing on a single IQ score as the cutoff. (American Association on Mental Deficiency, Classification in Mental Retardation (8th ed. 1983) p. 11 ("This upper limit [of IQ 70] is intended as a guideline; it could be extended upward through IQ 75 or more, depending on the reliability of the intelligence test used."); see also *id.* at p. 32 ("[T]he IQ of 70 as the upper limit of mental retardation is to be taken not as an exact but as an approximate number.").)

age increases, and to variances in the person's abilities or performance.”
(AAMR, Mental Retardation, 2002, *supra*, at p. 59.)⁶

This does not mean that the determination of whether an individual has significantly subaverage general intellectual functioning is somehow indeterminate or unmanageable, nor does it mean that the boundary of mental retardation is subject to manipulation. While this issue does not admit of a rigid rule involving a single, one-size-fits-all IQ score, experienced professionals in the field of mental retardation are fully competent to bring their clinical experience and judgment to the task, and to reach an individualized determination regarding a particular defendant. In cases in which expert evaluators disagree on the extent of a defendant's cognitive impairment, trial courts will be able to weigh the evidence supporting their differing opinions. As in any case involving disputed expert testimony, courts will be able to reach a judgment about whether the defendant's intellectual limitation falls within statutory and constitutional protections.

⁶ Accord, American Psychological Assn., Manual of Diagnosis and Professional Practice in Mental Retardation (Jacobson & Mulick edits., 1996) p. 27 (“Each intelligence or cognitive measure will differ in the clarity with which its structure permits isolation of specific cognitive functions.”). Clinical evaluators will also have to take into account changes in overall scoring over the life of a particular psychometric instrument. (Kanaya et al., *The Flynn Effect and U.S. Policies: The Impact of Rising IQ Scores on American Society Via Mental Retardation Diagnoses* (2003) 58 *Amer. Psychologist* 778, 779 (hereafter Kanaya, *Flynn Effect*).)

Defining mental retardation with a single inflexible IQ score as a requirement for the cognitive impairment prong is inconsistent with the professional experience of amici and their members. Such an arbitrary rule would impair the ability of both mental retardation professionals and the lower courts to achieve accurate and just results by considering the clinical evidence regarding each defendant claiming the protection of the Eighth Amendment.

B. DEFICITS IN ADAPTIVE BEHAVIOR

As noted earlier, cognitive impairment alone is not sufficient to support a diagnosis of mental retardation. The disability that appears in the results of IQ testing must also manifest itself as practical limitations on the individual's functioning in the world. The California statute describes this requirement in terms of "deficits in adaptive behavior." (Pen. Code, § 1376, subd. (a).)⁷ "Adaptive behavior is the collection of conceptual,

⁷ The requirement that cognitive impairment be accompanied by a practical disability has been described in various ways. A previous version of the AAMR manual specified that the low IQ must exist "concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work." (AAMR, *Mental Retardation: Definition, Classification and Systems of Supports* (9th ed. 1992) p. 5.) This formulation is also found in the American Psychiatric Association's diagnostic manual. (DSM-IV-TR, *supra*, at p. 41.) It has also been employed or referenced in judicial opinions and statutes. (See, e.g., *Atkins*, *supra*, 536 U.S. at p. 308, fn. 3; 725 Ill. Comp. Stat. Ann. 5/114-15(d) (West Supp. 2004).)

social, and practical skills that have been learned by people in order to function in their everyday lives.” (AAMR, Mental Retardation, 2002, *supra*, at p. 73.)

While there are numerous instruments available for assessing deficits in adaptive behavior,⁸ they lack the central importance of IQ tests in the assessment process. The basic inquiry for criminal courts is whether

The differences in terminology between the definitions, while important for assessing educational or habilitation needs, have little practical importance in evaluating criminal cases, since each encompasses the same group of disabled persons. Each formulation of the behavioral prong simply requires that there be a real-world limitation in the individual’s life. This assures clinicians that the low IQ score represents a real disability, and is not merely an anomaly resulting from an individual’s poor test-taking ability. (See generally AAMR, Adaptive Behavior and its Measurement: Implications for the Field of Mental Retardation (Schalock edit., 1999).)

⁸ There are more than 200 instruments available, “each purporting to measure adaptive behavior.” (Spreat, *Psychometric Standards for Adaptive Behavior Assessment* in AAMR, Adaptive Behavior and Its Measurement: Implications for the Field of Mental Retardation (Schalock edit., 1999) p. 103.) But unlike IQ tests, these are not primarily pencil-and-paper or other forms of questioning of the individual. Indeed, the individual is often an unreliable source of information on his or her own abilities. (See Everington & Keyes, *Diagnosing Mental Retardation in Criminal Proceedings: The Critical Importance of Documenting Adaptive Behavior* (1999) 8 *The Forensic Examiner* 31, 34.) By contrast, other persons in the individual’s life are often particularly helpful. “It is useful to gather evidence for deficits in adaptive functioning from one or more reliable independent sources (e.g., teacher evaluation and educational, developmental, and medical history).” (DSM-IV-TR, *supra*, at p. 42.) The precise content and approach of these adaptive behavior scales is a subject of considerable discussion among professionals in the field, but this inquiry focuses primarily on educational placement and habilitation issues, i.e., making sure the individual receives the optimal education and training. This is, of course, quite unrelated to the inquiry in a capital case.

there is a real-world impact of the intellectual impairment. If the defendant's low IQ is merely a testing anomaly, and produces no real-life limitation, the defendant does not have mental retardation.

For the criminal courts, the most important consideration regarding adaptive behavior is the universal clinical understanding that for practically every individual who has mental retardation, limitations coexist with strengths.⁹ This means that every individual with mental retardation who comes into contact with the criminal justice system will doubtless have skills, some of which will be beyond the ability of *other* individuals with mental retardation. The existence of such a skill or skills in an individual almost never precludes a diagnosis of mental retardation if all the other requirements of the definition are satisfied.¹⁰ Thus the proper clinical focus is limited to whether there are significant skills that the individual lacks.¹¹

⁹ See, e.g., AAMR, Mental Retardation, 2002, *supra*, at page 1; Davis, *Intelligence Testing and Atkins: Considerations for Appellate Courts and Appellate Lawyers* (2003) 5 J. Appellate Practice & Process 297, 304-307 (hereafter Davis, *Intelligence Testing*).

¹⁰ At first blush, it may seem incongruous that deficits should matter more in the clinical assessment of adaptive behavior than an individual's skills or strengths. This seeming paradox is explained by the purpose of the adaptive behavior prong: its function in the definition is not to assess the overall severity of an individual's disability; rather, it is designed to make certain that there *is* a real disability and not merely a testing anomaly.

¹¹ Therefore, to meet the needs of the criminal courts, every detail regarding adaptive behavior need not be catalogued as exhaustively as would be required when the goal of the assessment is to design an

The determination that the individual lacks such a skill or skills thus serves as confirmation that the IQ testing has identified a real disability.

C. AGE OF ONSET

Once a clinician has determined that a capital defendant has significantly subaverage general intellectual functioning and concurrent deficits in adaptive behavior, the only remaining inquiry is whether the disability manifested itself before the age of 18.¹² Here, the term “manifested” does not mean that there is a requirement of an IQ test administered during the individual’s childhood that indicated mental retardation.¹³ Often the “manifestation” will be in the form of evidence of adaptive skill deficits, such as repeated failure to meet developmental milestones during early childhood, school failure, etc. School records as

educational or habilitation plan in the context of a school or social service system. Once an adaptive behavior deficit has been established, the court will know all it needs to reach a determination on *Atkins* eligibility.

¹² Some other states phrase this requirement in terms of manifesting “during the developmental period.” The California Legislature specifies that onset must be before the age of 18. There is little, if any, practical difference between these two formulations.

¹³ Of course, the existence of such a test in the individual’s childhood could help confirm the age of onset. However, if there were a childhood test indicating mental impairment, but not mental retardation, it may be that the circumstances of the testing were less than reliable. (See generally Kanaya, *Flynn Effect, supra*, at p. 789.) On the general issue of cases that may involve diverging IQ scores for the same individual, see Baroff, *Establishing Mental Retardation in Capital Cases: An Update* (2003) 41 Mental Retardation 198.

well as the records of social service agencies may illuminate this issue. In other cases the most persuasive evidence, one way or the other, may come from neighbors, relatives, teachers, and others who knew the individual as a child, and who may have observed facts indicating disability or developmental problems.¹⁴

II. CLINICAL ASSESSMENTS OF MENTAL RETARDATION ARE ROUTINELY PERFORMED BY CLINICIANS WITH EXPERTISE IN MENTAL RETARDATION

For the trial courts to evaluate *Atkins* claims, they will require, in addition to a basic understanding of the definition of mental retardation, the assistance of evaluations by competent, experienced mental retardation professionals.¹⁵ Such evaluations must begin with the interpretation of

¹⁴ In practice, very few cases turn on the issue of age of onset. Almost everyone who has the requisite level of cognitive impairment and deficit in adaptive behavior has had the disability since birth or childhood. The only exceptions would be persons whose mental disability first occurred during adulthood, whether as a result of traumatic brain injury, dementia resulting from physical illness, or the like. Such individuals (who do not appear to be numerous in the caseload of the criminal courts) do not have mental retardation within the meaning of the clinical definition, and therefore do not fall within the protection of section 1376. The fact that their disability may raise comparable questions of culpability, as well as potential equal protection concerns, might appropriately be considered only in the context of an actual case involving such a defendant, should one arise.

¹⁵ “Because few judges, court personnel, lawmakers, or lawyers have any background in mental retardation evaluations or testing protocols (and indeed, relatively few psychologists and psychiatrists have extensive training in the detection of mental retardation), appellate courts should make use of experts on developmental disabilities and testing. Common

appropriately administered psychometric testing, but must also include careful examination of the evidence concerning the presence or absence of deficits in adaptive behavior in the individual's life.¹⁶ Particular caution is appropriate regarding the testimony of evaluators whose experience is in the field of mental illness, but who do not have substantial training and experience in the field of mental retardation.¹⁷

While it is important for trial courts to give careful consideration to clinical evidence in mental retardation cases, amici wish to emphasize that

knowledge about mental retardation should be considered no more authoritative than lay understanding of any scientific issue, such as DNA evidence or pathologists' findings. Grave mistakes could be made if appellate courts base determinations about mental retardation on intuitive feelings about mental retardation or the ways in which people with mental retardation should act." (Davis, *Intelligence Testing*, *supra*, at p. 307.)

¹⁶ A somewhat fuller discussion of some aspects of clinical evaluations can be found in *Legislative Guide*, *supra*, at page 14 and the sources cited therein. (See generally American Psychological Assn., *Manual of Diagnosis and Professional Practice in Mental Retardation* (Jacobson & Mulick edits., 1996); AAMR, *Mental Retardation*, 2002, *supra*, at pp. 51-96; Melton et al., *Psychological Evaluation for the Courts: A Handbook for Mental Health Professionals and Lawyers* (2d ed. 1997); Parry and Drogin, *Criminal Law Handbook on Psychiatric and Psychological Evidence and Testimony* (American Bar Association 2000) pp. 70-71.)

¹⁷ Keyes et al., *Mitigating Mental Retardation in Capital Cases: Finding the "Invisible" Defendant* (1998) 22 *Mental & Physical Disability L.Rptr.* 529, 535 ("The assessment, diagnosis and treatment of this population [people with mental retardation] is sometimes very different than the 'typical' patient. Training in traditional mental health graduate programs includes little, if any, information about mental retardation."); Olvera et al., *Mental Retardation and Sentences for Murder: Comparison of Two Recent Court Cases* (2000) 38 *Mental Retardation* 228, 232-233.

judges should not view this as an unduly complex or burdensome task. Evaluating such evidence is something that courts already do in a variety of legal contexts, and the inquiry is certainly less subjective and problematic than many other issues that courts routinely address. (See *Heller v. Doe* (1993) 509 U.S. 312, 322 [113 S.Ct. 2637, 2644, 125 L.Ed.2d 257, 272] (“[The] basic premise that mental retardation is easier to diagnose than is mental illness has a sufficient basis in fact.”).)

III. THE ATKINS ISSUE IS SEPARATE AND DISTINCT FROM THE DOCTRINES OF COMPETENCE TO STAND TRIAL AND INSANITY

Mental retardation is, of course, the same clinical phenomenon, regardless of whether the legal issue in an individual case is competence to stand trial, the insanity defense, or death penalty eligibility. But it is vitally important that when trial courts are evaluating *Atkins* claims, they keep the differences in legal doctrines clearly in mind.

A defendant’s mental retardation can, in some cases, substantially limit the ability to understand the proceedings or to assist counsel.¹⁸ In those cases, it would be unconstitutional to bring the defendant to trial at

¹⁸ See *Dusky v. United States* (1960) 362 U.S. 402, 402 [80 S.Ct. 788, 789, 4 L.Ed.2d 824, 825]; *People v. Samuel* (1981) 29 Cal.3d 489 [174 Cal.Rptr. 684, 629 P.2d 485]; Penal Code section 1367, subdivision (a) (“as a result of mental disorder *or developmental disability*”) (emphasis supplied).

all.¹⁹ Other defendants who are competent to stand trial may have a complete defense against conviction that is based on their mental retardation.²⁰ Since neither of these groups of defendants could lawfully be convicted, the *Atkins* limitation on capital punishment would not arise in their cases.²¹

CONCLUSION

The *Atkins* decision and Penal Code section 1376 reflect the constitutional and public policy judgments that the death penalty should never be imposed on an individual who has mental retardation. Guaranteeing the faithful implementation of those principles will require

¹⁹ See *Cooper v. Oklahoma* (1996) 517 U.S. 348, 354 [116 S.Ct. 1373, 1376, 134 L.Ed.2d 498, 505-506], *Medina v. California* (1992) 505 U.S. 437, 453 [112 S.Ct. 2572, 2581, 120 L.Ed.2d 353, 368]; *People v. Hayes* (1999) 21 Cal.4th 1211, 1281 [91 Cal.Rptr.2d 211, 260, 989 P.2d 645, 689] (interpreting California Constitution). See generally Bonnie, *The Competence of Criminal Defendants with Mental Retardation to Participate in Their Own Defense* (1990) 81 J. Crim. L. & Criminology 419.

²⁰ *In re Ramon M.* (1978) 22 Cal.3d 419, 421 [149 Cal.Rptr. 387, 389, 584 P.2d 524, 526] (a “rarely used defense” in mental retardation cases).

²¹ The Attorney General’s apparent confusion on this point is puzzling. The Informal Response to Petition for Writ of Habeas Corpus asserts that the test for *acquittal* announced in *Ramon M.* should also be the test for relief from the death penalty under *Atkins*. (Informal Response at p. 7.) It is even suggested that protecting all defendants with mental retardation, as *Atkins* clearly mandates, would somehow constitute an Eighth Amendment violation under *Furman v. Georgia* (1972) 408 U.S. 238 [92 S.Ct. 2726, 33 L.Ed.2d 346]. (Informal Response at p. 9.)

trial courts to conduct careful fact-finding, with the assistance of knowledgeable and experienced mental retardation professionals, and unfettered by the false precision of arbitrary boundaries or limitations. Surely, no lesser standards should be applied in a capital case, where the individual's life is at stake.

Respectfully submitted,

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CERTIFICATION OF COMPLIANCE
(CALIFORNIA RULES OF COURT, RULE 36(b)(2))
CAPITAL CASE

I certify that the foregoing BRIEF OF THE AMERICAN ASSOCIATION ON MENTAL RETARDATION AND THE ARC OF THE UNITED STATES, AMICI CURIAE, uses a 13 point Times New Roman font and contains 4,685 words.

The original and all copies of this Brief made for service and filing have been printed on 100% recycled paper pursuant to Rule 14(b)(1) of the California Rules of Court.

Dated: November 8, 2004

James W. Ellis

DECLARATION OF SERVICE

In re Anderson Hawthorne, No.: S116670

I declare that I am a professor at the University of New Mexico School of Law, and am admitted to practice in the District of Columbia. My business address is 1117 Stanford, N.E. Albuquerque, New Mexico 87131. I am over the age of eighteen years and I am not a party to above entitled action. I served the attached BRIEF OF THE AMERICAN ASSOCIATION ON MENTAL RETARDATION AND THE ARC OF THE UNITED STATES, AMICI CURIAE by:

Causing copies of the attached to be placed in a sealed envelope for collection and mailing via the United States Post Office to:

Bill Lockyer
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I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge. This proof of service is executed at Albuquerque, New Mexico on November 8, 2004.

James W. Ellis